

Shadow Mountain

Camper No. _____ (Registration is on a first come first serve basis for those students currently enrolled in fifth grade in Nebo School District. Due to the high demand for Shadow Mountain only one registration per person will be accepted during walk up registration).

Registration Form Summer 2009

Student Name: _____

Home Phone: _____ **Cell** _____

Address: _____

School: _____

Preferred Camp Dates: _____ **T-Shirt Size** Youth _____ (or) Adult _____
 Youth (s m l) Adult (S M L XL)

Male _____ **Female** _____

Parents **Father** _____ **Work Phone** _____ **Cell** _____
Mother _____ **Work Phone** _____ **Cell** _____

Please list two people we may contact in case of an emergency and we cannot contact you:

Name _____ **Phone #** _____
Name _____ **Phone #** _____

Check all items that apply, **past** or **present**, to your health history. Explain any "Yes" answers (Use the back if needed).

ALLERGIES: Food, medicines, insects, plants Yes: _____ No: _____

Explain: _____

GENERAL INFORMATION:	Yes	No	Yes	No	Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Please list ALL medications taken in the 30 days prior to arrival at Shadow Mountain: _____

List any prescription medications to be taken at camp (**Please have medications in a plastic zip-lock bag with campers name written in permanent marker on the bag. Include written instructions of the drug to be given, dosage, and frequency**). All over the counter drugs (Advil, allergy/hay fever..) will remain with your camper to be used as needed/determined by your camper.

List any physical or behavioral conditions that may affect or limit full participation in hiking, running, or playing strenuous physical games:

Safety is a primary concern at Shadow Mountain. We have made every effort to minimize risks in this program. All activities are carefully controlled and supervised by certified teachers and/or technicians. Regardless of the precautions we take, there will always be some risk in a program of this nature. This is an outdoor camp. The students participate in hikes, games and other activities in the outdoors. Our safety record has been outstanding. However, please be aware that **Nebo School District does not carry medical or accidental insurance for the campers. Insurance will be your responsibility.**

I give permission for dispensing of prescription medication as noted above and for full participation in Shadow Mountain programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me or my designees. In the event I cannot be reached, I hereby give my permission to the licensed health care practitioner selected by the adult leader in charge to secure proper treatment. I realize that I am responsible for providing medical insurance for my child.

Parent or Legal Guardian's Signature _____

Please make checks payable to Shadow Mountain.

For Office Use Only:

Paid \$ _____ check _____ cash _____ Initial _____

Check # _____

Note: _____

Cut on line

Camper No. _____

**Receipt for
Shadow Mountain Program
Summer 2009**

Student Name: _____ **School** _____

T-Shirt Size _____

Paid \$ _____ on Date: _____ by Check # _____ Cash _____

Verification: _____

(Signature)

This receipt is for your records. It is not necessary to bring it to camp. If after registration you decide to cancel, a \$25.00 cancellation fee will be assessed against the registration fee.